PATIENT INFORMATION ALL INFORMATION MUST BE COMPLETED PRIOR TO REGISTRATION THE BELOW INFORMATION IS TO BE FILLED OUT ON THE PATIENT BEING SEEN TODAY

| LAST NAME: | |
|----------------------------------|--|
| FIRST NAME: | |
| MIDDLE INITIAL: | |
| SUFFIX: | _ (Jr., Sr, 1 st , 2 nd etc) |
| SS#:RE | QUIRED FOR HEAD OF HOUSEHOLD |
| RELATIONSHIP TO HEAD OF H | HOUSEHOLD: |
| BIRTH DATE: | |
| NICKNAME: | |
| SEX: | |
| DO YOU OR ONE PARTICIPAT SCHOOL: | E IN THE FREE LUNCH PROGRAM AT |
| IF YES, EFFECTIVE WHAT DATE | B: |
| BILLING ADDRESS : | |
| HOUSE#: | |
| | : (NORTH, SOUTH, EAST, |
| WEST) | |
| NAME OF STREET: | (AVE, ST, RD ETC) |
| POST DIRECTION: | (NE SW ETC) |
| APT #: | (NE, 5W ETC) |
| ZIP CODE: | |
| CITY: | |
| STATE: | |

| HOME ADDRESS: | |
|---|--|
| HOUSE#: | |
| PRE-DIRECTION OF ADDRESS: | (NORTH, SOUTH, EAST, |
| WEST) | |
| NAME OF STREET: | |
| STREET SUFFIX: | (AVE, ST, RD ETC) |
| POST DIRECTION: | (NE, SW ETC) |
| APT #: | |
| ZIP CODE: | |
| CITY: | _ |
| STATE: | |
| TELEPHONE NUMBERS: | |
| DO NOT LIST A NUMBER BELOW TH | AT YOU WOULD NOT WANT US TO |
| CALL | .11 100 ((0022 1(01 ((1211 05 10 |
| | |
| HOME: | |
| HOWE. | |
| CELL: | |
| CEEL | |
| SCHOOL: | |
| SCHOOL | |
| WODK. | |
| WORK: | |
| INCOME DETAILS | |
| INCOME DETAILS | |
| Does anyone in the family have Medicaid? | Voc. No. |
| Does anyone in the family have Medicald: | 1 es1\u0 |
| Doog anyone in the family have Unicare? V | Zog No |
| Does anyone in the family have Unicare? Y | .esNo |
| Doog anyone in the family have Famig/Med | Jollian? Wag No |
| Does anyone in the family have Famis/Med | iamon: 1esNo |
| D | ¥7 N |
| Does anyone in the family have Medicare? | YesNo |
| Decree and all the straight to | 0 X7 NI |
| Does anyone in the family have Health Inst | arance? YesNo |
| TO and a second of the latest the second of | L |
| If yes to any question above – list below w | no is covered by what insurance and |
| attach copy of card for verification? | |
| | |
| Name of covered person(s) | |
| | |
| | |
| | |
| | |
| You are required to show their card for eli | gibility purposes each time they visit |
| clinic. | |

| FOR HEALTH DEPARTMENT USE ONLY: |
|---------------------------------|
| HIPPA: |
| TIME IN: |
| SCHEDULER: |